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UNDERSTANDING THE INDIAN PUBLIC HEALTH SYSTEM IN A FEDERAL STRUCTURE

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Abstract:

Health services in India are delivered by a diverse set of public, for-profit and not-for-profit private providers. India has a federal structure of governance with national and state jurisdiction over policies. Since independence, the Indian government has made efforts to improve the health standard of the citizens. The health plans in India are set according to the vision of global institutions for which India is a signatory. The national government plays an overall stewardship role, providing vision and funds to the policies and programmes. State governments play a more prominent role in combining the role of vision, leadership, funding, regulation and delivery of health care. This article deals with the public health system in India.

Keywords: *Health sector, Healthcare system, Public Health, Federalism.*

1. INTRODUCTION

India has a rich past in the field of medical sciences. The *'Charaka Samhita" and "Sushruta Samhita" were the* two foundational texts of this field that have survived from ancient India. The *'Charaka Samhita"* was the mainstay of medicine for centuries and *"Sushruta Samhita"* was the ancient medical compendium of surgery compiled around the 6th century B.C. Both physical and mental health were considered significant parameters of health.

The Buddhist era in the 6th century B.C. saw the establishment of *"Viharas"* - monasteries for the care of the sick, impoverished, and disabled, as well as medical education. Several hospitals were operational throughout King Ashoka's reign in the 2nd century B.C. Modern hospitals and healthcare systems were constructed. From the late 19th century through the early 20th century, the first medical colleges were established for organized medical training. Further, dispensaries were established at the sub-division and district level and hospitals at the provincial level were attached to

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medical colleges (Ministry of Health and Family Welfare, 2020, September 20).

The present focus on public health evolved slowly across the globe. The broad foundations of public health later evolved when Winslow defined public health as "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals." Winslow CEA (Winslow, 1920).

2. EMERGENCE OF HEALTH PLANNING IN INDIA

The National Planning Committee in 1938 under the chairmanship of Jawahar Lal Nehru, the Bombay Plan, and the Gandhi Plan were the foreword to health plans in India. The plans were set within different frameworks of economic development. None of the plans went into the details of health planning but provided an overall framework for the development sector.

Since independence, the Indian government has made efforts to improve the health standard of the citizens. The health plans in India are set according to the vision of global institutions for which India is a signatory. National Population Policy and National Health Policy have stressed long-term health goals. The goals are to be accomplished through improvement in the access, availability and affordability of health care to the citizens, especially the marginalised section, the rural population of the country.

The Bhore Committee of 1946 was set up with the principle that "nobody should be denied access to health services for his inability to pay". The focus was on rural areas with importance on preventive measures and training of social physicians. In Independent India, there has been a series of committees like the Sokhey Committee in -1948, the Mudaliar Committee- in 1962, the Chadha Committee- in 1963, the Katar Singh Committee- in 1973, Srivastava Committee- in 1975, the Indian Council of Medical Research- Indian Council of Social Science Research (ICMR-ICSSR) Joint Panel (1980) that focussed on the health care delivery system in India (Qadeer, 2008).

In India, national and state governments have command over policies as India has a federal system of governance. In the health sector, decision-making, planning and health delivery systems are decided by the Union and state governments. The Union government through wide consultation with multiple stakeholders, Regional consultations, approval of the Central Council of Health and Family Welfare, a Group of Ministers and various Committee recommendations has shaped health policy and planning in India (National Health Policy-2017, March 31).

3. INDIAN PUBLIC HEALTH SYSTEM

Healthcare services are delivered by both public and private providers. The

delivery of health services through the public sector in India follows the three-tier structure of primary, secondary, and tertiary health care services. This covers both rural and urban areas. Apart from public institutions, there are private providers, individual practitioners, and private hospitals, again which are subject to a variety of regulations with various levels, although challenges remain.

3.1. CONSTITUTIONAL PROVISION OF HEALTH

Under the Indian Constitution of India, health is a state subject, and the implementation of health programmes is entrusted to state governments (Ministry of Health & Family Welfare, 2021 November 30). State governments play a more prominent role in the delivery of health care. The Indian Constitution outlines "Public Health, Sanitation, Hospitals and Dispensaries" as a state subject, curative care which deals with hospitals, dispensaries, sanitation and so on comes under the purview of the state. The institutions are accountable to local administrative authorities and the Right to Information Act as well.

The union government is responsible for varied preventive and promotive health programmes like maternal and child health, family planning, programmes related to the control of communicable and non-communicable diseases, promoting an indigenous system of medicine and so on. Hospitals attached to port facilities for quarantine or seamen's hospitals are exclusively under the jurisdiction of the Central Government. Policy formulation and regulation on health insurance are largely under the jurisdiction of the Central Government,

"Population Control and Family Planning", "adulteration of foodstuff", control of infectious and contagious diseases across state boundaries and issues governing the medical profession are placed under the Concurrent List where both the Central Government and the state governments have jurisdiction. However, areas having wider implications at the national level, such as medical education, family welfare and population control, quality control in the manufacture of drugs, and prevention of food adulteration, are governed jointly by the union and the state government. Social health insurance (SHI) is in the Concurrent List, paving the way for state-level policy formulation (Seventh Schedule - Article 246.).

3.2. AN OVERVIEW OF THE HEALTH SYSTEM

Health services in India are delivered by a diverse set of public, for-profit and not-for-profit private providers. These providers vary by patterns of ownership and organization. Alternative systems of medicine, commonly known as Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) supplement allopathic health providers. Health services in the public system include both curative and preventive services. Public sector health services under the ambit of the ministries at the national level and

departments of health at the state level are financed from the general revenues of governments (Selvaraj S, 2022).

3.2.1. PRIMARY HEALTHCARE

Primary Health Centres essentially deliver preventive, promotive, basic curative, palliative, and rehabilitative services encompassing community and programmatic requirements. Primary healthcare services in India have now been delivered through Sub-centres and Primary Health Centres in rural areas and Urban Primary Health Centres in urban areas.

Population norm for Health Centres- Primary healthcare services

i. **HWC-SHC (Rural):** In rural areas, one Sub Health Centre is established for every 5000 population in plain areas and 3000 population in hilly/tribal/desert areas.

ii. **UHWC (Urban):** In urban areas, one Urban-HWC per 15,000-20,000 population caters predominantly to poor and vulnerable populations, residing in slums or other such pockets.

iii. **Rural PHC:** PHC in rural areas is to be established for a population of 20,000 (in hilly and tribal areas) and 30,000 (in plains).

iv. **Urban PHC:** UPHCs are established for every 50,000 population, and in close proximity to urban slums.

v. **Polyclinic:** Multispecialty Polyclinics provide specialist healthcare services to a population of 2.5 to 3 lakhs, encompassing the catchment population of 5-6 UPHCs.

Table 1: Population norm for Health Centres- Primary healthcare services

Sl. No.	Type of PHC facility	Plain (population)	Hilly/Tribal(population)
1	HWC-SHC	5000	3000
2	UHWC	15,000-20,000	-
3	Rural PHC	30,000	20,000
4	Urban PHC	50,000	-
5	Polyclinic	2.5 lakh – 3 lakh	-

Source: Indian Public Health Standards Health and wellness Centre - Primary Health entre Volume-III, Ministry of Health & Family Welfare.

3.2.2. SECONDARY HEALTHCARE

District Hospital, Sub-District Hospital and selected Community Health Centres (CHCs) and Urban Community Health Centres (UCHCs) deliver secondary health care in rural and urban areas. CHCs in rural areas can be either non-FRU CHC or FRU CHC, the UCHC in urban areas will function only as FRU UCHCs. Non-FRU CHCs will have 30 essential beds. For FRU CHCs in rural areas, 30 beds, maternity and surgical services will be essential while in a 50 bedded FRU CHC, additional ophthalmic, orthopaedic, and ENT services will be desirable. Similarly, for FRU UCHCs 50 beds, maternity and surgical services will be essential in all the cities. The same with 100 beds (in metropolitan cities/cities with population of more than 1 million), will have additional ophthalmic, and orthopaedic services as desirable.

i. **Community Health Centre (Rural):** CHC in rural areas is to be established for a population norm of 80,000 (in hilly and tribal areas) and 1,20,000 (in plains) and/or time to care approach.

ii. **Community Health Centre (Urban areas):** UCHC in urban areas is set up as a secondary care referral centre in metro cities with a population of 5 lakh and above and population of 2.5 lakh in non-metro cities.

Table 2: Population norm for CHCs

Sl. No.	Type of CHC facility	Plain (population)	Hilly/Tribal (population)
1.	Community Health Centre (Rural)	1,20,000	80,000
2.	Community Health Centre (Urban areas)	5lakh above in metro cities 2.5lakh in non-metro cities	-

Source: Indian Public Health Standards Health and wellness Centre - Primary Health entre Volume-II, Ministry of Health & Family Welfare.

District and Sub District hospitals will provide secondary care services. Sub District hospitals are below the district and above the block level (CHC) hospitals and act as Referral Units for the /Taluk population. Every district should have at least one district hospital which should be comprehensively functional for providing secondary care services. For estimating the number of in-patient hospital beds required in a district, the population of the district should be assessed against standards for bed requirement and also review the relative contributions of the public and private health sector. Districts with less than 5 lakh population with a functional DH do not need a Sub District hospital. Districts with populations between 5-10 lakh can have one SDH. Thereafter, one SDH for every 10 lakh population can be considered for the provision of comprehensive secondary care health services (Welfare M. o., Indian Public Health Standards Sub District Hospital and District Hospital Volume - I).

3.2.3. TERTIARY CARE FACILITIES

Above the level of district hospitals, tertiary care is provided by medical colleges and/or state-level super-speciality hospitals. Medical colleges and super-speciality hospitals at the state level receive support directly from state health departments. In recent years, several tertiary-care hospitals on the lines of the All India Institute of Medical Sciences (AIIMS) (India's main tertiary-level health facility in the public sector) have been set up in states to provide high-end tertiary care and serve as apex teaching institutions, funded directly by the Central Government (Selvaraj S, 2022).

4. PUBLIC HEALTH FACILITIES - PHYSICAL INFRASTRUCTURE

As per the Rural Health Statistics (RHS) 2020, as of 31.3.2020 the status of public health facilities function in the Country is as under

Table 3: Public Health Facilities

Sl.No	Details of Health centre	Total
1	Sub Centres (SCs)	1,57,921
2	Primary Health Centres (PHCs)	30,813
3	Community Health Centres (CHCs)	5,649
4	Sub-divisional Hospitals (SDHs)	1193
	Districts Hospitals (DH)	810

Source: National Health Mission. (2023). Department of Health & Family Welfare.

There is a shortfall of 46140 SCs (24%), 9231 PHCs (29%) and 3002 CHCs (38%) across the country as per the Rural Health Statistics (RHS) 2020.

4.1. PUBLIC HEALTH INFRASTRUCTURE IN KARNATAKA

The state has made remarkable progress in improving its health infrastructure at different levels in both rural and urban areas. As per SDG India index 3.0- 2020-2021, the performance of Karnataka state is in 6th place scoring an index of 78, behind Gujarath (86), Maharastra (83) and Tamil Nadu (81).

The Karnataka State has a wide institutional network providing health services both in urban and rural areas. The primary health infrastructure in rural areas has fulfilled the norms required under the "Minimum Needs Programme" at the aggregate level. Currently, 9188 SCs, 2176 PHCs, and 189 CHCs are in place, against the required 8024 SCs, 1318 PHCs and 329 CHCs in rural areas of Karnataka. Except for CHCs, there is no shortfall in the required SCs, & PHCs. In urban settings, there are 358 PHCs in place against the required 575, amounting to a shortfall of 38%. In tribal catchments, there are 291 SCs, 65 PHCs and 7 CHCs in place, against the required 1153 SCs, 173 PHCs and 43 CHCs. This accounts to a shortfall of 74.76% of the required SCs, 62.43% of the required PHCs and 83.72% of the required CHCs in the tribal areas. There are 26 DHs, 150 SDHs and 19 government medical colleges in the state. (Kotwal, 2021).

Further 31215 private medical establishments are registered under the Karnataka Private Medical Establishment Act for providing quality care according to medical ethics by prescribing service quality of which 9871 (32%) are in Bangalore district alone followed by Dharwad 2092 (7%) and Dakshina Kannada 1980 (6%) (KAG 2020-21).

5. NATIONALMEDICAL COMMISSION

In 2020, a new National Medical Commission (NMC) was established along with the four Autonomous Boards of UG and PG Medical Education Boards, Medical Assessment and Rating Board, and Ethics and Medical Registration Board have also been constituted to help the NMC in day to day functioning by the Indian Parliament, replacing Medical Council of India to the growth of a well-functioning and good-quality medical education sector. (Ministry of Health and Family Welfare, 2020 September 25).

6. REGULATION OF HEALTH SYSTEM IN INDIA

Regulation of health-care providers, pharmaceutical industry, and quality of drugs, medical devices and allied systems is important for the functioning of the health system and ensuring well-being of the patient.

6.1. REGULATORY CONTROL OVER DRUGS: The objective of the drug regulatory system is to ensure availability of safe, effective and quality drugs, cosmetics and medical devices based on scientific excellence and best possible regulatory practices. Under the provision of the Drugs and Cosmetics Act, 1940 & Rules, 1945 control over the import, manufacture, distribution and sale of drugs, cosmetics and notified medical devices in the country are regulated. The manufacture, sale and distribution of drugs in the country is primarily regulated by the State Drug Control Authorities appointed by the State Governments while control over drugs imported into the country and approval of new drugs are exercised by the Central Government through Central Drugs Standard Control Organisation-CDSCO.

6.2. INDIAN PHARMACOPOEIA COMMISSION (IPC):

The IPC has been continuously striving hard to set standards for drugs, to promote rational use of medicinal products through generic medicines, running Pharmacovigilance Programme of India (PvPI), Materio-vigilance Programme of India (MvPI), and Skill Development Programme.

6.3. MEDICAL STORES ORGANISATION (MSO): The MSO was set up in the year 1942, as a wing of Directorate General of Health Services (DGHS). It has 07 Government Medical Store Depots (GMSDs), in New Delhi, Mumbai, Kolkata, Chennai, Hyderabad, Karnal and Guwahati. They not only store and stock essential drugs and vaccines but also provide last mile logistics support to deliver stocks to health care units across the country.

6.4. CLINICAL ESTABLISHMENTS ACT, 2010 & NATIONAL COUNCIL FOR CLINICAL ESTABLISHMENTS:

The Act was envisaged to registration of all types of health facilities to enforce common minimum standards of quality for diagnosis and treatment. After passing of the Clinical Establishments Act by the Parliament in August 2010 and notification by the MoHFW, the Act initially came into force in the four States of Sikkim, Mizoram, Arunachal Pradesh and Himachal Pradesh and all UTs (except NCT of Delhi) on 01.03.2012. Subsequently seven more States, namely Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Rajasthan, Assam and Haryana adopted the Act. Barring a few exceptions, most Indian states have not implemented the Clinical Establishments Act, 2010. Thus as on date, the Clinical Establishments Act, 2010 is applicable in 11 States and 5 Union Territories.

17 States/ UTs which have not adopted Clinical Establishments (Registration and Regulation) Act, 2010 but have their own Act viz. Andhra Pradesh, Maharashtra, Madhya Pradesh, Punjab, Odisha, West Bengal, Telangana, Chhattisgarh, Tamilnadu, Meghalaya, Kerala, Karnataka, Manipur, Nagaland, Tripura, Goa and Delhi. 3 States/ UTs which have neither adopted Clinical Establishments (Registration and Regulation) Act, 2010 nor have their own Act viz. Gujarat, Jammu & Kashmir and Ladakh.

7. EXPENDITURE ON PUBLIC HEALTH :

India is a federal economy; health is the shared responsibility of the centre and the state governments. The Union Ministry of Health and Family Welfare is responsible for various programmes at the national level. The centre is responsible for designing various programmes, and the states need to implement them. The Centre assures this through the fiscal power it has in the allocation of resources. Maintenance and upkeep of facilities up to the district hospital level is essentially the responsibility of the state government, with the Central Government providing part funding through the NHM.

The NHM's core focus areas have evolved from its focus on reproductive, maternal, newborn and child health services to additionally include adolescent health services, health system strengthening, and tackling other communicable and non-communicable diseases. Under the National Health Mission (NHM), financial support is provided to States to strengthen the public health system including the upgradation of existing or construction of new infrastructure. Under NHM's high focus states can spend up to 33% and other States up to 25% of their NHM funds on infrastructure.

7.1. EXPENDITURE ON PUBLIC HEALTH IN INDIA

Reconciling with the vision of providing healthcare services to all, which is one of the policy recommendations of the National Health Policy 2017, the Government is focusing on healthcare expenditure. The central and state governments' budgeted expenditure on healthcare touched 2.1 % of GDP in FY23 and 2.2% in FY22, against 1.6% in FY21, as per the Economic Survey 2022-23 tabled in Parliamen. (Mint, 2023). The National Health Account (NHA) estimates for FY19 show that there has been an increase in the share of government health expenditure in the GDP from 1.2% in FY14 to 1.3% in FY19. Perhaps, the share of Government Health Expenditure in total health expenditure has also increased over time, standing at 40.6% in FY19, substantially higher than 28.6% in FY14.

The Economic Survey 2022-23 report cites, that overall, for FY19, Total Health Expenditure for India is estimated to be 5,96,440 crore (3.2 per cent of GDP and 4,470 per capita). Current Health Expenditure (CHE) is 5,40,246 crore (90.6 per cent of THE) and capital expenditures

are 56,194 crore (9.4 per cent of THE). Of the GHE, the Union Government's share is 34.3 per cent and the State Governments' share is 65.7 per cent.

The primary Health Care Expenditure has increased from 51.1 per cent in FY14 to 55.2 per cent in FY19. This not only ensures quality services at the grassroots level but also reduces the chances of ailments requiring secondary or tertiary healthcare services. Between FY14 and FY19, the share of primary and secondary care in the Government Health Expenditure increased from 74.4 per cent to 85.7 per cent. On the other hand, the share of primary and secondary care in private health expenditure has declined from 82.0 per cent to 70.2 per cent during the same period (Economic Survey 2022-23)

7.2. EXPENDITURE ON PUBLIC HEALTH IN KARNATAKA

During 2022-23 in Karnataka, the amount allocated in the budget under various Health schemes to provide health facilities is Rs.9614.00 crores of which productive allocation is Rs. 5808.81 crores. The amount of release is Rs.6397.20 crores of which productive release is Rs. 3014.16 crores. The expenditure incurred up to January 2023 is Rs. 6706.34 crores of which productive expenditure is Rs.3122.49 crores (Economic Survey 2022-23)

8. CONCLUSION

Regulatory efforts of Clinical Establishments Act, 2010 & National Council for Clinical Establishments to ensure the quality of health services in India face a continued resistance from the States and medical fraternity from becoming a reality. Regulation of private players constitute an on-going challenge. The Central and state drug regulatory authorities, ensuring good quality drugs remains challenging for India's health system. Various professional councils are mandated to regulate and establish norms and standards for the medical, nursing, dental and allied health worker professions. Existing systems for regulation of medical education in India are lax and variable. Multiple authorities, contributing to the poor implementation of rules and regulations. A cooperative federalism with the major role given to state and creating the public health cadre at state, district and block level enable the environment to create strong health system across the country. To meet the sustainable development goals in delivering universal health coverage the public health system need an adequate investment to strengthen the health care service and withstand any kind of pandemic, epidemic and health emergencies.

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